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**NEBRASKA  
MENTAL HEALTH BOARD TRAINING**

***SELF-STUDY HANDBOOK***

*Division of Behavioral Health Services*  
NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

In Compliance with the Statutory Requirement to Provide Annual Training to Members of Nebraska Mental Health Boards    Neb. Rev. Stat. 71-916 or 204 NAC 6 (Nebraska Administrative Code Chapter 6)

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Nebraska Mental Health Board Training  
**SELF STUDY HANDBOOK**

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## **STUDY GUIDE OBJECTIVES:**

Provide information for Mental Health Board members to assist in decision-making at commitment hearings

### **To accomplish the objective, readers will:**

- Gain an appreciation of the role of the Mental Health Board in preserving an individual's rights and ensuring due process at Mental Health Board hearings
- Know the implications for Mental Health Board decisions arising from the cases of Olmstead, Wickwire, and Albert
- Become aware of the elements contained in a five Axis diagnosis from the most current edition of DSM (Diagnostic and Statistical Manual of Mental Disorders) and the content of a mental status exam
- Apply the criteria of magnitude, imminence, likelihood and frequency in making determination of dangerousness to self and to the public
- Identify the difference between substance abuse and substance dependency
- Learn the State definition of dual disorder
- Use the statutory requirement for least restrictive level of care, to commit to outpatient/community based services
- Have a list of questions to ask at hearings to gain the clear and convincing proof of mental illness and dangerousness needed to make a commitment decision

## Excerpts from the Nebraska Mental Health Commitment Act

### **71-924**

#### **Mental Health Board; duties**

A hearing shall be held by the mental health board to determine whether there is **clear and convincing evidence** that the subject is mentally ill and dangerous as alleged in the petition. At the commencement of the hearing, the board shall inquire whether the subject has received a copy of the petition and list of rights accorded him or her by sections **71-943** to **71-960** and whether he or she has read and understood them. The board shall explain to the subject any part of the petition or list of rights which he or she has not read or understood. The board shall inquire of the subject whether he or she admits or denies the allegations of the petition. If the subject admits the allegations, the board shall proceed to enter a treatment order pursuant to section **71-925**. If the subject denies the allegations of the petition, the board shall proceed with a hearing on the merits of the petition.

Source: laws 1976, LB 806 § 45; Laws 1981, LB 95, § 14; R.S. 1943, (1999), §83-1035; Laws 2004, LB 1083, § 44.

Operative date July 1, 2004.

### **71-907**

#### **Mentally Ill Defined**

Mentally ill means have a psychiatric disorder that involves a severe or substantial impairment of a person's thought processes, sensory input, mood balance, memory, or ability to reason which substantially interferes with such person's ability to meet the ordinary demands of living or interferes with the safety or well-being of others.

Source: Laws 1977, LB 204, § 27; R.S. 1943, (1999), § 83-1009.01; Laws 2004, LB 1083, § 27.

Operative date July 1, 2004.

## Responsibility of the Mental Health Board

According to **71.924**, the duty of the Mental Health Board is to determine at a hearing whether there is clear and convincing proof that the person before them is a mentally ill and dangerous person.

Further, **71.925** provides that the board must also determine that neither voluntary hospitalization nor less restrictive alternative level of care would prevent harm to themselves or others. The first step in the commitment process is an assessment and clinical decision regarding the presence of mental illness, to which a mental health professional will testify at a hearing. It is important to ask the clinician what other levels of care and services were considered by the treatment team before arriving at the placement recommendation to the board.

If there is a finding of mental illness, the board next makes a legal decision regarding danger to self or others. If criteria for dangerousness are met, a third decision arises, whether commitment to community based/outpatient treatment will satisfy the needs of the person and public safety; or if the choice of last resort, inpatient commitment, is necessary.

The level of evidence needed to make a commitment decision is *clear and convincing evidence*. This is less than the *beyond reasonable doubt* required for a criminal conviction, but more than the *preponderance of the evidence* needed in the usual civil case. The board serves as final decision-maker, determining if a person's civil liberties must be taken from them **temporarily** to protect the person or society in exchange for needed treatment for mental health and/or substance dependency. By questioning the mental health professional, county attorney, defense counsel, and the person themselves, the board will obtain evidence to support a decision: (1) for release; (2) a commitment to a community based service which best meets safety and treatment

needs; or (3) commitment to an acute inpatient service either at a State Regional Center or hospital contracted with one of the six behavioral health regions.

Functioning as a neutral fact-finder in a legal court proceeding where civil justice is dispensed, board members have judicial immunity from potential liability.

### **Inpatient Commitment Orders and Warrants.**

NRS Sec. 71-925 (4) provides in part:

If the subject is ordered by the board to receive inpatient treatment, the order shall commit the subject to the custody of the Department of Health and Human Services for such treatment.

The foregoing was a change in the statutes enacted in July, 2004 and was enacted to eliminate orders that commit a subject to a specific regional center, which historically caused problems for both the subject and the regional centers. By virtue of 71-925 (4), if the board desires to commit a subject to inpatient treatment, the order must recite that the subject is placed in the custody of HHS.

**Suggested Warrant of Inpatient Admission Form** is located at (Appendix I or - [www.hhss.ne.gov/beh/commit.htm](http://www.hhss.ne.gov/beh/commit.htm)).

Sec 71-931 requires every treatment order to include directions for the preparation and implementation of an individualized treatment plan. The treatment plan would include:

- (a) the nature of the subject's mental illness or substance dependence,
- (b) the least restrictive treatment alternative consistent with the diagnosis, and
- (c) intermediate and long-term goals for the subject and a projected timetable for the attainment of such goals.

The individualized treatment plan is to be filed with the board, as well as included in the subject's file and served on the county attorney, subject's file and served on the county

attorney, subject's counsel, and guardian, if any, within 5 working days after entry of the board's order. Treatment is to commence within two days after preparation of the plan.

**Suggested individualized treatment plan form** is located at ( Appendix H or [www.hhss.ne.gov/beh/commit.htm](http://www.hhss.ne.gov/beh/commit.htm)).

By the time the inpatient commitment order has been drafted, the mental health board should have already been in touch with HHS and Magellan to determine where appropriate placement in the HHS system lies. See 71-925(7). Although the commitment order itself does not specify commitment to a specific facility, law enforcement will be directed by the mental health board via the warrant to place the subject at a specific facility. Pertinent statutes relating to inpatient warrants may be found at 71-927, 71-928 and 71-929.

#### Synopsis of 71-927

When a subject is ordered to receive inpatient treatment and ordered to the custody of HHS, the Department has the duty to secure placement of the subject in appropriate inpatient treatment facility. The board then has the duty to issue a warrant authorizing the administrator of the specific treatment facility to receive and keep the subject as a patient.

**Suggested Warrant of Inpatient Admission form** is located at ( Appendix I or [www.hhss.ne.gov/beh/commit.htm](http://www.hhss.ne.gov/beh/commit.htm)).

The warrant shall state:

- the findings of the board
- the legal settlement of the subject, if known, or any available information
- the specific treatment facility to receive and keep the subject as a patient

According to 71-927, the warrant "shall shield every official and employee of the treatment facility against all liability to prosecution of any kind on account of the reception and detention of the subject if the detention is otherwise in accordance with the

Nebraska Mental Health Commitment Act...” (Appendix A or [www.hhss.ne.gov/beh/commit.htm](http://www.hhss.ne.gov/beh/commit.htm)).

### Synopsis of 71-928

When a subject is ordered to receive inpatient treatment, the findings of the mental health board and warrant shall be delivered to the sheriff or other suitable person appointed by the board to execute the warrant. Although the statutes do not delineate the term, “findings” could reasonably be interpreted to mean, among other things, a copy of the order of commitment.

Upon receipt of the warrant from the board, the sheriff (or other appointed person) has the responsibility of delivering the warrant, the findings and the subject to the treatment facility as designated on the warrant. No female subject shall be taken to a treatment facility without being accompanied by another female or relative of the subject.

71-928 provides that the sheriff (or other appointed person) may take with him/her such assistance as may be required to execute the warrant.

The administrator of the treatment facility has the responsibility to acknowledge the delivery of the warrant by signing the same. The administrator, in the acknowledgement of delivery, shall also record whether any person accompanied the subject and the name of such person. The sheriff has the duty to return the warrant to the clerk of the district court along with his/her costs.

### Synopsis of 71-929

71-929(1) outlines the procedure if advance funds are needed to pay the sheriff or other suitable person for the admission or return of a subject to a treatment facility.

71-929(2) details what the sheriff shall include in his statement of expenses when he executes upon the warrant.

71-929(3) details how the sheriff shall be reimbursed for expenses incurred in conveying a subject to a treatment facility.

71-929(4) changed the MHCA in 2004 by specifically setting forth that the *county* is responsible for payment of transport costs associated with the admission or return of a subject to a treatment facility. Prior to the enactment of this section, the statutes were silent as to who was responsible for payment of such expenses to the sheriff (or other suitable person). The new language in the state provides:

“(4) All compensation and expenses provided for in this section shall be allowed and paid out of the treasury of the county by the county board”.

### **Outpatient Commitment Orders and Warrants.**

71-925(6) authorizes outpatient commitment by the board. That statute dictates that the order of the board “shall represent the appropriate available treatment that imposes the least possible restraint upon the liberty of the subject...Inpatient hospitalization or custody shall be considered as a treatment of last resort.” As was previously discussed in regards to inpatient commitments, Sec. 71-931 also requires every outpatient treatment order to include directions for the preparation and implementation of an individualized treatment plan.

**Suggested Outpatient Commitment Order Form** is located at (Appendix J or [www.hhss.ne.gov/beh/commit.htm](http://www.hhss.ne.gov/beh/commit.htm)).

Unlike the statutes pertaining to the placement of inpatient commitments (71-927 to 71-928), the law does not specify how the board is to secure placement of the subject following an order of commitment to an outpatient treatment facility.

Sec. 71-933 set forth a process to be followed in an outpatient setting that allows the board to intervene to protect the subject or others. The outpatient treatment provider has the duty to report to the board and the county attorney if:

- (a) the subject is not complying with the individualized treatment plan
- (b) the subject is not following conditions set by the board
- (c) the treatment plan is not effective
- (d) there has been a significant change in the subject's mental illness or substance dependence.

The county attorney has the duty to investigate the report. If the county attorney determines the report has no factual basis, no further action need be taken other than notifying the board. If the county attorney determines that there is a factual basis for the report and that intervention by the board is necessary to protect the subject or others, the county attorney may motion the matter back before the board for further hearing.

The county attorney has the option of applying for a warrant to take the subject into immediate custody pending hearing if the county attorney believes the subject poses a threat of danger to himself or others. The application for a warrant must be supported by an affidavit or sworn testimony of the county attorney or "any informed person".

71-933(2)(d). Sworn testimony may be taken telephonically at the discretion of the board.

71-934 states that the board may, on its own motion or through a motion filed by the county attorney, hold a hearing to determine whether an outpatient subject can be adequately and safely served by the individualized treatment plan on file. Pending hearing, the board may issue a warrant directing any law enforcement officer to take custody of the subject and to transport the subject to a treatment facility. No subject is to

be held for more than seven days unless the board grants a continuance. At the time of execution of the warrant, the subject is to be personally served with a motion and notice of hearing, along with a list of rights guaranteed to the subject under the Act. Following hearing, the board determines if outpatient treatment will be continued, modified or ended.

### **Review Hearings**

71-935(1) provides that upon the filing of the periodic report, the subject is entitled to a hearing within 14 days of his request to seek an order of discharge or a change in treatment. The board also has the authority to schedule a review hearing:

- (a) at any time a treatment facility notifies the board of its intent to release the subject from its custody pursuant to 71-937 or at any time the board feels it necessary to determine whether the subject is adhering to the conditions of his release
- (b) upon request of the subject, the subject's counsel, the subject's legal guardian or conservator, if any, the county attorney, the entity designated to oversee the subject's individualized treatment plan
- (c) upon the board's own motion

Such hearings have the same due process protections as are afforded in the commitment hearings. 71-935(2) the board has the authority at a review hearing to discharge the subject or enter a new treatment order.

### **Notice of Discharge**

71-937 provides that the treatment facility is supposed to notify the board in writing of the release of the subject, which notice is to be immediately forwarded to the county attorney. Further:

“The mental health board shall, upon the motion of the county attorney, or may upon its own motion, conduct a hearing to determine whether the individual is mentally ill and dangerous and consequently not a proper subject for release. “

### **Post Release Conduct Hearings**

71-938 provides for a hearing to “determine whether a person who has been ordered by the board to receive inpatient or outpatient treatment is adhering to the conditions of his or her release from such treatment, including the taking of medication.” The hearing may be held on the board’s own motion or upon a motion filed by the county attorney. A finding that the subject is mentally ill and dangerous by clear and convincing evidence mandates that the board enter an order of final disposition providing for the treatment of such person in accordance with section 71-925.”

### **Escape from Treatment Facility**

71-939 states that when a subject is absent without authorization from a treatment facility, the administrator shall immediately notify the Nebraska State Patrol and the court or clerk of the mental health board of the judicial district from which such person was committed.

The notice shall include:

- the person’s name
- a description of the subject
- a determination by a psychiatrist, clinical director, administrator, or program director as to whether the person is believed to be currently dangerous to others.

The clerk shall issue the warrant of the board directed to the sheriff of the county for the arrest and detention of such person.

**Suggested Warrant of Inpatient Admission Form** is located at (Appendix I or [www.hhss.ne.gov/beh/commit.htm](http://www.hhss.ne.gov/beh/commit.htm)).

Any law enforcement officer may execute such warrant. Pending the issuance of the warrant, any peace officer may seize and detain such person when the peace officer has probable cause to believe that the person is reported to be absent without authorization. Such person shall be returned to the treatment facility or shall be placed in facility for emergency protective custody as described in 71-919 until the subject can be returned to the treatment facility. **Suggest Warrant of Arrest Form** (Appendix G or [www.hhss.ne.gov/beh/commit.htm](http://www.hhss.ne.gov/beh/commit.htm)).

## **Personal Rights of Subjects**

### Rights of a subject of a mental health board proceeding for commitment of a mentally ill and dangerous person.

#### **A. Procedural rights**

1. To written notice of the time and place of hearing.
2. To notice of the reasons alleged for believing the subject is a mentally ill and dangerous person who requires Mental Health Board Ordered treatment
3. To receive a copy of the petition.
4. To a list of his/her rights.
5. To the label of the mental disorder of the subject unless the physician or mental health professional on the board determines that it is not prudent to disclose the label of the mental disorder to the subject, then notice of this label may be disclosed to the subject's counsel rather than the subject. When the subject does not have counsel, the subject has a right to the information about his or her mental illness including its label.
6. To inquiry by the Board as to whether the subject has read and understood the petition and list of rights.
7. To a lawyer (Board appointed if the subject is indigent)
8. To access (either in person or through his/her attorney) all evidence and information including the label given to the alleged mental illness.
9. To an independent evaluation by physicians or clinical psychologists and to have their testimony and assistance in the subjects behalf. If the subject is indigent, the reasonable cost of the evaluation and related professional assistance in the subject's behalf will be paid by the Board.
10. To have continuances liberally granted.
11. To closed hearings unless the subject requests that they be open.
12. To be present at all hearings and present witnesses and information defending against the petition
13. To subpoena witnesses to testify for the subject's defense.
14. To confront and cross examine witnesses and evidence
15. To have rules of evidence applicable in civil proceedings apply to Board hearings.
16. To testify or refuse to testify.
17. To be free of such quantities of medication or other treatments prior to any Board hearing as would substantially impair his/her ability to assist in his/her defense at the hearing.
18. To written statements by the Mental Health Board about the evidence relied upon and the reasons for finding clear and convincing proof at the hearing that the subject is a mentally ill and dangerous person, that less restrictive alternatives are

not available or feasible to prevent the harm and for the choice of the particular treatment ordered.

19. To have the Board's written findings made part of the person's record.
20. To have all proceedings be of record
21. To appeal the decision of the Mental Health Board to the District Court and to appeal a final order of the District Court to the Court of Appeals

B. Rights while in custody or Board ordered treatment.

1. To be considered legally competent for all purposes (ie. Voting, contracts, use of money, marriage, divorce, etc.) unless one has been declared legally incompetent.
2. To receive prompt and adequate evaluation and treatment for mental illness and physical ailments and to participate in one's treatment planning activities (to the extent deemed appropriate by the mental health professional responsible)
3. To refuse treatment medication, except (a) in an emergency, such treatment as is essential in the judgment of the mental health professional in charge of such treatment to prevent the subject from causing injury to himself, herself or others or (b) following a hearing and order of a mental health board, such treatment medication as will substantially improve his or her mental illness.
4. To communicate freely with all persons by sealed mail, personal visitation or private telephone communications.
5. To have reasonably private living conditions, including private storage space for personal belongings.
6. To engage or refuse to engage in religious worship and political activity.
7. To be compensated for labor in accordance with the fair labor standards act.
8. To have access to a grievance procedure
9. To file writs of habeas corpus to challenge the legality of his or her custody or treatment.
10. To have his/her records remain confidential except as otherwise provided by law.
11. To have access to his/her records unless ordered otherwise by the Court.

Rights of a subject of a mental health board proceeding for commitment of a dangerous sex offender

A. Procedural rights

1. To written notice of the time and place of hearing.
2. To notice of the reasons alleged for believing the subject is a dangerous sex offender who requires Mental Health Board Ordered treatment
3. To receive a copy of the petition.
4. To a list of his/her rights.
5. To the label of the mental disorder of the subject unless the physician or mental health professional on the board determines that it is not prudent to disclose the label of the mental disorder to the subject, then notice of this label may be disclosed to the subject's counsel rather than the subject. When the subject does not have counsel, the subject has a right to the information about his or her mental illness including its label.
6. To inquiry by the Board as to whether the subject has read and understood the petition and list of rights.
7. To a lawyer (Board appointed if the subject is indigent)

8. To access (either in person or through his/her attorney) all evidence and information including the label given to the alleged mental illness.
9. To an independent evaluation by physicians or clinical psychologists and to have their testimony and assistance in the subject's behalf. If the subject is indigent, the reasonable cost of the evaluation and related professional assistance in the subject's behalf will be paid by the Board.
10. To have continuances liberally granted.
11. To closed hearings unless the subject requests that they be open.
12. To be present at all hearings and present witnesses and information defending against the petition
13. To subpoena witnesses to testify for the subject's defense.
14. To confront and cross examine witnesses and evidence
15. To have rules of evidence applicable in civil proceedings apply to Board hearings.
16. To testify or refuse to testify.
17. To be free of such quantities of medication or other treatments prior to any Board hearing as would substantially impair his/her ability to assist in his/her defense at the hearing.
18. To written statements by the Mental Health Board about the evidence relied upon and the reasons for finding clear and convincing proof at the hearing that the subject is a dangerous sex offender and, that less restrictive alternatives are not available or feasible to prevent the harm and for the choice of the particular treatment ordered.
19. To have the Board's written findings made part of the person's record.
20. To have all proceedings be of record
21. To appeal the decision of the Mental Health Board to the District Court and to appeal a final order of the District Court to the Court of Appeals

B. Rights while in custody or Board ordered treatment.

1. To be considered legally competent for all purposes (ie. Voting, contracts, use of money, marriage, divorce, etc.) unless one has been declared legally incompetent.
2. To receive prompt and adequate evaluation and treatment for mental illness and physical ailments and to participate in one's treatment planning activities (to the extent deemed appropriate by the mental health professional responsible)
3. To refuse treatment medication, except (a) in an emergency, such treatment as is essential in the judgment of the mental health professional in charge of such treatment to prevent the subject from causing injury to himself, herself or others or (b) following a hearing and order of a mental health board, such treatment medication as will substantially improve his or her mental illness.
4. To communicate freely with all persons by sealed mail, personal visitation or private telephone communications.
5. To have reasonably private living conditions, including private storage space for personal belongings.
6. To engage or refuse to engage in religious worship and political activity.
7. To be compensated for labor in accordance with the fair labor standards act.
8. To have access to a grievance procedure
9. To file writs of habeas corpus to challenge the legality of his or her custody or treatment.
10. To have his/her records remain confidential except as otherwise provided by law.
11. To have access to his/her records unless ordered otherwise by the Court.



## **LB 1199 SUMMARY**

### **LB 1199 (Bourne) Change provisions relating to sex offenders.**

LB 1199 provides crimes and penalties regarding sexual assault of a child, provides civil commitment for sex offenders, provides for community supervision of sex offenders, changes provisions of the Sex Offender Registration Act, adopts the Sexual Predator Residency Restriction Act and establishes a working group to study sex offender treatment and management services.

#### **CRIMES AND PENALTIES:**

A person commits sexual assault of a child in the first degree if he or she subjects another person under 12 years old to sexual penetration and the actor is at least 19 years of age or older. Sexual assault of a child in the first degree is a Class IB felony with a mandatory minimum sentence of 15 years in prison for first offense. Any person who is found guilty of sexual assault of a child in the first degree under this section of law and who has prior convictions of sexual assault shall be guilty of a Class IB felony with a mandatory minimum sentence of 25 years in prison.

Sexual assault of a child is in the second degree if the actor causes serious personal injury to the victim. Sexual assault of a child in second degree is a Class II felony for the first offense. Any person found guilty of this offense and who has prior convictions of sexual assault shall be guilty of a Class IC felony and shall be sentenced to a mandatory minimum term of 25 years in prison.

Sexual assault of a child is in the third degree if the actor does not cause serious personal injury to the victim and is a Class IIIA felony for the first offense. Any person who is guilty of this offense and has prior sexual assault convictions shall be guilty of a Class IC felony.

Time limitations for prosecution or punishment will not apply to these sexual assault crimes.

#### **CIVIL COMMITMENT:**

LB 1199 provides a process for emergency protective custody of dangerous sex offenders. Such persons shall be admitted to an appropriate and available medical facility unless they have a prior sex offense conviction. If such persons have a prior sex offense conviction, they shall be admitted to a jail or Department of Corrections unless a medical or psychiatric emergency exists.

LB 1199 adopts the Sex Offender Commitment Act. The purpose of this act is to provide for the court-ordered treatment of sex offenders who completed their sentences, but continue to pose a threat of harm to others. It is the public policy of this state that dangerous sex offenders be encouraged to obtain voluntary treatment. This act provides for the civil commitment of dangerous sex offenders. The procedures such as filing of petition, mental health board hearings, treatment orders,

commitments, execution of warrant and rules of evidence mirror the current Mental Health Commitment Act. The language, Sex Offender Commitment Act, is incorporated into the current mental health commitment statutes.

At least 90 days prior to the release of a sex offender, the agency with jurisdiction over such individual shall notify the Attorney General, Nebraska State Patrol, prosecuting county attorney and the county attorney in which an individual is incarcerated, supervised or committed. Also, the Board of Parole shall notify these same parties within 5 days after scheduling a parole hearing. Further, a county attorney shall, no later than 45 days after receiving notice of the pending release of a sex offender, notify the Attorney General whether he/she intends to initiate civil commitment proceedings against such individual upon their release.

LB 1199 creates a separate legal standard for sex offenders. This standard defines dangerous sex offender as a person:

- who suffers from a mental illness which makes the person likely to engage in repeat acts of sexual violence, who has been convicted of one or more sex offenses and who is substantially unable to control his/her criminal behavior or
- with a personality disorder which makes the person likely to engage in repeat acts of sexual violence, who has been convicted of two or more sex offenses and who is substantially unable to control his/her criminal behavior.

This bill requires the Department of Corrections to order evaluations for offenders convicted of first degree sexual assault, repeat offenders, child predators who refuse treatment and offenders who have violated the Sex Offender Registration Act. This evaluation shall be ordered at least 180 days before the release of the individual. Upon completion of this evaluation, this department shall send written notice to the Attorney General, county attorney of the county where the offender is incarcerated and the prosecuting county attorney. An affidavit of the mental health professional shall be included in the notice.

#### COMMUNITY SUPERVISION:

LB 1199 provides for lifetime community supervision of sex offenders. Upon completion of his/her term of incarceration or release from civil commitment, the following classes of sex offenders will be supervised in the community by the Office of Parole Administration (Office) for the remainder of his/her life:

- Repeat sex offenders,
- offenders convicted of sexual assault of a child in the first degree or
- offenders convicted of penetration of a victim 12 years or more through the use of force or threat of serious violence or victim under the age of 12 years of age.

Lifetime community supervision applies to any of these individuals, on or after the effective date of this act.

The agency or political subdivision which has custody of such individuals shall notify the Office at least 60 days prior to release. Such individuals shall undergo a risk

assessment and evaluation by the Office. Conditions of community supervision imposed by the Office are provided.

Individuals that violate one or more of the conditions of community supervision shall undergo a review by the Office. The Office may revise or impose additional conditions, request prosecution by Attorney General or county attorney or recommend civil commitment. Criminal penalties are provided.

LB 1199 provides duties for parole officers. Also, this bill provides notification and supervision duties for the Office. Such individuals are entitled to an appeal whenever there is a determination or revision of conditions of community supervision. An appeal process is provided. In addition, notification requirements to such individuals are provided for the sentencing court.

Prior to the release of a person serving a sentence an offense requiring lifetime community supervision, the Department of Corrections, Department of Health and Human Services, or city or county correctional or jail facility shall provide written notice that he/she shall be subject to lifetime community supervision by the Office. This notice shall inform the person that he/she is subject to a lifetime community supervision, consequences of violations of conditions and right to challenge the determination of the conditions. Also, these agencies or county/city jails must require the defendant to read and sign a form stating they understand these conditions and retain a copy of the written notification.

#### SEX OFFENDER REGISTRATION ACT:

LB 1199 expands the list of offenses that require registration under this act. Specifically, the offenses of sexual assault of a child in second or third degree, sexual assault of a child in the first degree and debauching a minor are included. Also, any person who enters the state and is required to register as a sex offender under the laws of another state, territory, commonwealth or other U.S. jurisdiction must register in this state.

LB 1199 clarifies the reporting requirements of sex offenders under this act. Within 5 working days, persons under this act must notify, in writing, the sheriff of any changes in address, employment, vocation, school of attendance, temporary domicile, and name change.

LB 1199 provides additional requirements for courts and the Department of Corrections relating to informing the defendant that fingerprints and a photograph will be obtained by any registering entity in order to comply with the registration requirements.

Public notice provisions are expanded to allow disclosure of information of sex offenders under community supervision to the Office of Parole Administration. Also, information of sex offenders working at or attending a postsecondary educational institution must be disclosed to law enforcement or campus police.

This bill increases the penalty for second convictions for failing to comply this act. Also, persons who have violated this act and have been committed to the Department of Corrections are required to attend treatment and counseling programs.

#### SEXUAL PREDATOR RESIDENCY RESTRICTION ACT:

This bill allows a political subdivision to enact an ordinance, resolution, or other legal restriction prescribing where sex offenders may reside only if the restrictions are limited to sexual predators and extend no more than 500 feet from a school or child care facility. Exemptions for correctional institutions, treatment facilities and dates of establishing a residence are provided. Ordinances, resolutions or other legal restrictions are void if they do not meet the requirements of this act.

#### SEX OFENDER WORKING GROUP:

The Director of Regulation and Licensure shall establish a working group to study sex offender treatment and management services and recommend improvements. This working group shall include a member of the Legislature appointed by the Executive Board of the Legislative Council. The Governor shall appoint a representative from HHS, Corrections, Probation System, Board of Parole, law enforcement, courts, private providers of this treatment, and victim advocates. Also, the Governor shall appoint a licensed psychologist, licensed alcohol and drug counselor and sex offender participating in a treatment program. Other interested persons may be appointed in a nonvoting capacity as needed.

This working group shall study sex offender treatment and management on the state level to determine future legislative and executive actions. These actions shall be based on the recommendations of the 2001 Governor's Working Group on the Management and Treatment of Sex Offenders report involving credentialing of professionals providing this treatment, mandated treatment standards and increased training opportunities for these professionals.

The Director of Regulation and Licensure, in consulting with this working group, shall submit a report of this study to the Legislature and Governor by December 1, 2006. This working group terminates on December 1, 2006.

LB 1199 becomes effective July 14, 2006.

## Precedent Setting Legal Cases

Three court cases setting legal precedent for mental health boards may have an impact on commitment decisions and should be noted: those of Olmstead, Wickwire, and Albert. These cases involve (1) the mandate for least restrictive placement; (2) the lack of jurisdiction over a person with mental retardation; and (3) the importance of obtaining the required training set by law for mental health board members.

The Olmstead v. L.C., 527 U.S. 581 (1999) case involved a person held in a Georgia mental institution who wanted community placement. Using the Americans with Disabilities Act as reference, the Supreme Court found that it is discriminatory to provide services in an institution when an individual could be served more appropriately in a community-based setting. It was argued that unjustified retention is a form of discrimination limiting exposure to the outside community; that a person's rights were violated when held in an inappropriate level of care. The ruling applies when treatment professionals determine community placement appropriate and transfer from institutional care to community setting is agreed to by the individual. Also, the placement must be reasonably accomplished by the state, taking into consideration the resources of the state and the needs of the mentally ill person.

Nebraska's decision In re Wickwire 259 Neb. 305, 609 NW2d 384 (Neb. 2000) concerned an individual with an IQ of 40, considered to be mentally retarded who did not have a diagnosis of mental illness. His developmental disability included serious behavioral issues and, due to his aggressive and violent behavior, the Lancaster County Attorney filed a mental health board petition stating that Wickwire was a mentally ill and dangerous person, recommending inpatient placement at the Lincoln Regional Center. However, psychiatrists at Lincoln Regional Center testified that treatment at a psychiatric hospital would not benefit Wickwire, due to his diagnosis of mental retardation, not

mental illness. The court ruled that although the mental health board found him a dangerous person, they had no jurisdiction over persons with mental retardation; and that the state of Nebraska did not intend the terms “mental illness” and “mental retardation” to be used interchangeably.

In another Nebraska District court case, from Platte County District court, (August 24, 2001), a mental health board decision was declared null and void because two of the three board members had not completed mental health board training as required by statute within the past two years as required by statute. Statute 71.916 still makes mental health trainings mandatory. Albert had served time in prison for first degree sexual assault. At the time of his release, a petition was filed under the Mental Health Commitment Act and he was committed to Norfolk Regional Center as a mentally ill and dangerous person. Albert brought a writ of habeas corpus, alleging that he was unlawfully imprisoned because the actions of the board were void, due to their not having followed the law requiring yearly training for board members. The court found for Albert and he was discharged.

#### New Law/Cases

1. The new Mental Health Commitment Act, NRS Sec. 71-901 et seq., became effective July 1, 2004. There were two changes in the MHCA that became effective July 1, 2005.
  - (i.) **NRS Sec. 71-906.** The legislature expanded the definition of “mental health professional” to include an advanced practice registered nurse who has certification in a mental health specialty, as well as a person licensed to practice medicine and surgery or psychology.
  - (ii.) **NRS Sec. 71-922.** The legislature mandated that board proceedings are deemed to have commenced upon the earlier of (a) the filing of a petition or (b) notification by the county attorney to the law enforcement officer who took the subject into emergency protective custody or the administrator of the treatment center having charge of the subject of his or her intention to file such petition. The county attorney shall file such petition as soon as reasonably practicable after such notification.

2. **In re Interest of E.M.** 13 Neb. App. 287 (2005) examined 83-1045.02, which provides that “no person may be held in custody pending the hearing for a period

exceeding seven days, except upon a continuance granted by the board.” The language remains essentially the same in the new MHCA at 71-934, which provides “no person may be held in custody under this section for more than seven days except upon a continuance granted by the board”.

The subject in E.M. was taken into custody on September 17, 2003 and the hearing was held on September 25. The subject argued that he was denied his statutory right to a hearing within 7 days of being taken into custody.

**Held:** “The ‘seven days’ language of Section 83-1045.02 is directory, not mandatory, and that even assuming the provision was violated in this case, violation of the provision does not mandate dismissal of the proceedings.” 13 Neb. App. 287 (2005) at 294.

**3. In re Interest of Verle O.**, 13 Neb. App. 256 (2005). In 1993, Verle entered a plea of “no contest” to attempted first-degree sexual assault on a child in a criminal case and was incarcerated. Nine years later, at the time the Verle was to be discharged from the department of corrections, the state filed a petition with the mental health board alleging Verle was mentally ill and dangerous. Under Section 83-1009 [re-codified at 71-908], there must be a recent violent act, a threat of violence, or an act placing others in reasonable fear in order to find that a person is dangerous. The Board found Verle to be mentally ill and dangerous, but failed to specify any specific recent violent act or threat of violence that would make Verle dangerous as required by statute. Instead, the board relied on the no contest plea and statements made on the record by Verle at that plea hearing as the factual basis for finding Verle mentally ill and dangerous.

**Held:** By entering a plea of no contest (as opposed to entering a guilty plea), Verle avoided making any admissions of fact; therefore, any statements made by Verle in connection with the no contest plea were not admissible as evidence in the civil commitment proceeding. The mere fact that Verle plead no contest to an attempted assault does not in and of itself establish that Verle performed recent violent acts as required by statute. Additional facts must be established to sustain a commitment.

## **Board Determination of Mental Illness**

### *1. Overview of Mental Illness*

The first determination a mental health board must make is whether a person is mentally ill, alcoholic, or drug abusing. In the scope of the commitment process, “mentally ill” is considered to include alcoholics and drug abusers. Mental illness is not defined in the Act. A psychiatrist, a licensed clinical psychologist or a APRN is allowed by law to diagnose mental illness and will present an evaluation of the person appearing before the board. By statute a licensed alcohol and drug abuse counselor (LADAC) can diagnose substance dependency and other substance abuse issues. If board members have

questions about the reported diagnosis, symptoms, or behaviors of a person appearing before them, it is important to question the mental health professional or LADAC and to receive answers.

Clinicians use the latest edition of DSM, the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association as the standard for diagnostic criteria in determining mental illness. There are five Axis categories in a diagnosis:

Axis I -- Mental Illness, and or substance abuse or  
..dependence

Axis II -- Personality disorders, mental retardation

Axis III -- Physical conditions and disorders

Axis IV -- Psycho-social and environmental problems, stresses  
(housing, support group, occupation, education, social, legal  
system problems, accessing health care)

Axis V -- GAF (Global Assessment of Functioning; the rate of  
current overall occupational, psychological and social  
functioning expressed as a single number on a 1 to  
100 point scale) Low to Normal = 75-100.

Mental illness can be viewed as a collection of symptoms, either behavioral or psychological, which cause an individual distress, disability, or an increased risk of suffering, pain, disability, death, or loss of freedom. Mental illness can be a thinking disorder such as schizophrenia with its characteristic delusions and hallucinations; or a mood disorder with depression; anxiety, panic disorder; a bipolar disorder which may have cycles of depression and mania; behavior disorders; personality disorders; or alcohol and drug dependence disorders.

A mental status examination is an evaluation of a person's current mental functioning, which aids a clinician in arriving at a diagnosis. A typical mental status exam (MSE) covers the following areas:

- Appearance and Behavior: dress, grooming, posture, physical characteristics, facial expression, eye contact, motor activity, cooperation
- Speech: rate, loudness, amount, clarity
- Emotions: mood—depressed, anxious, euphoric, angry
- Thought: Suicidal or homicidal ideation, logic, flow of ideas, content, delusions, preoccupations or obsessions, phobias
- Perception: presence of auditory, visual, tactile, olfactory hallucinations
- Insight and Judgment: orientation to time, place, person, concentration, memory, fund of knowledge, judgment, insight or awareness of mental illness, intelligence

## 2. *Overview of Substance Abuse versus Substance Dependence*

Substance abuse or substance dependency are terms often heard when a board listens to testimony at a hearing. It is necessary to differentiate between abuse and dependency. *Substance addiction, substance dependence and chemical dependency* refer to an **addiction**, while *substance **abuse*** is *temporary use of alcohol or other drugs which cause problems in a small part of an individual's life*. Abusers are able to recognize the relationship between their alcohol and/or drug use, the problems it causes and can stop their abuse with a little help and encouragement.

In dependence, use of the substance becomes progressively worse. A diagnosis of dependency includes meeting the criteria of increased tolerance, withdrawal symptoms, and a pattern of compulsive use. Persons who are dependent continue using substances in spite of increasingly severe consequences in personal and social lives and physical health.

Common symptoms of dependency are: 1) increasing episodes of intoxication; 2) loss of interest in other pursuits; 3) loss of control over usage; 4) repeated remorse over the results of substance use; 5) increased tolerance to the drug (including alcohol); 6) negative reactions to withdrawal from the drug (Best direct evidence of alcoholism is the

appearance of withdrawal symptoms one to two days after last drinking alcohol); 7) memory failures as a result of use; 8) serious personal and social consequences resulting from substance use such as problems with relationships, work, or with the law.

Intoxication by itself doesn't indicate dependency. However when episodes of intoxication occur with increasing frequency, involving larger amounts of a substance due to tolerance, resulting in increasingly severe personal and social consequences over an extended period of time--a diagnosis of dependency is almost certain. Other indicators for alcohol dependence are:

- Drinking at or before breakfast
- Drinking non-beverage forms of alcohol (Rubbing alcohol, cologne, etc.)
- Traffic difficulties (DUI, DWI arrests)
- Problems at work related to alcohol use
- Relationship problems related to usage; fighting associated with drinking
- Inability to stop drinking even if the person has wanted to
- Drinking binges
- Black outs (a person has no memory of his behavior or events although during that time he appeared conscious and aware)

### *3. Overview of "Dual Disorders & Dual Disorder Treatment"*

As more and more persons present with multiple problems and illnesses in the commitment process, there is an increasing need to understand the differences between dual disorders, dual disorder treatment and dual enhanced treatment for co-occurring disorders. Understanding the differences between these levels of duality will help the Mental Health Board be able to make appropriate decisions for the least restrictive placement of a person depending upon the severity of the dual issues presented.

A **dual disorder** occurs when an adult has a primary Axis I severe and persistent mental illness (SPMI) diagnosis and a primary Axis I substance dependency diagnosis. It

is important to remember that there are only a few mental illnesses that are included within the category of **severe and persistent mental illnesses**: schizophrenia or schizoaffective disorder, bipolar disorder, major depression, and other psychotic disorders. It is also important to know that substance dependency is much more severe and chronic than substance abuse. **Dependency** is a pattern of repeated substance use that results in tolerance, withdrawal, and compulsive substance-taking behavior, where substance abuse does not include these characteristics. The essential feature of dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating continued use despite significant substance-related problems. In combination, these two diagnoses (SPMI/SD) present unique problems for Mental Health Boards in determining the least restrictive treatment placement while ensuring public safety.

There are only a few persons that meet this severe level of dual disorder. The Mental Health Board should carefully determine if the subject in the hearing has this level of severity to be considered dually diagnosed. Dual disorder clients eligible for **dual disorder treatment** will exhibit more unstable or disabling levels of SPMI and dependency. The typical client is disabled to such a degree that specific psychiatric and mental health support, monitoring and accommodation are necessary in order to participate in simultaneous addiction treatment. It is also important to determine if the acute symptoms are stabilized or, if the subject needs further stabilization before being able to benefit from a dual treatment program. The subject must not display symptoms of intoxication and must be stable on psychotropic medication(s) in order to be admitted to a community based dual treatment program. Often a short stay at an acute inpatient program for psychiatric stabilization, and then a move to a community based dual disorder residential treatment program provides the most appropriate primary integrated treatment to address both the mental illness and the substance dependency problems simultaneously.

When a person with a mental illness such as schizophrenia acquires a substance dependency, serious consequences result. There can be more severe impairments while using lesser quantities, less frequently. There is a higher risk of non-compliance with mental health treatment, in fact, they are eight times more likely to be non-compliant with medications. Psychiatric symptoms fluctuate more rapidly and are more severe. In addition, there are increased mood swings, more psychiatric re-hospitalizations, violent acting out behavior, suicidal ideation, and suicide attempts. If a person with substance dependency has established an entrenched pattern of chronic use, hallucinations, manic behavior, suicide ideation and delusionary behavior can occur resulting from the habitual use of substances.

A person with a dual disorder requires specific psychiatric and mental health support and monitoring in order to participate in treatment for alcohol and/or drug addiction. Due to the multiple problems, they need an individualized and flexible approach to treatment. The supportive, non-threatening approach is more therapeutic for a dually diagnosed person whereas a confrontive approach would be difficult to tolerate, especially if symptoms of paranoia are present.

#### *4. “Overview of Co-Occurring Disorders & Dual Enhanced Treatment”*

An increasingly common diagnosis is when the subject has a primary mental illness and a secondary substance use or abuse disorder, OR a primary substance abuse disorder and a secondary mental illness. These combinations of dual issues are termed **Co-occurring disorders** and are appropriate for **dual enhanced treatment**. Dual enhanced treatment is for persons whose mental illness or substance disorder is less active than the primary diagnosis. Providers(mental health or substance abuse) of these treatment services may elect to “enhance” their primary service to address the client’s other relatively stable diagnostic or sub-diagnostic co-occurring disorder. The primary

focus of such programs is either mental health OR abuse/dependency treatment rather than dual diagnosis concerns and is not a primary, integrated dual disorder treatment.

Alcohol is the substance most frequently used by persons with mental illnesses, followed by cocaine, marijuana and methamphetamine. About 50% of persons in a psychiatric clinical setting will have a substance disorder. The lifetime prevalence of a substance disorder in persons with schizophrenia is 47%; in those with bipolar disorder, it is 56%; and in those with major depression, it is 27%. Research studies show that 29% of people with an Axis I psychiatric disorder will have a substance abuse disorder at some time in their lives. Persons with mental illness report similar reasons as the general population for using substances: attempting to improve unpleasant moods such as anxiety and depressions, increasing social interaction, and increasing pleasure by feeling “high”. While mentally ill persons may use substances in order to deal with symptoms, people without mental illness can display psychotic symptoms due to substance use, such as anxiety, panic, mood swings, hallucinations, delusions, amnesia, personality changes, insomnia, and eating-disordered behavior. Both dependence and psychosis feature loss of control of behavior and emotions, and in both instances symptoms respond to treatment.

It is difficult for strictly substance abuse treatment agencies to serve a dually disordered person in their population just as it is difficult for strictly mental health treatment agencies to serve the dually diagnosed person. It is important to note that Nebraska’s Regional Centers provide dual enhanced treatment for co-occurring disorders only. They do not have integrated dual disorder treatment programs nor are they equipped to served the dually diagnosed client. The specific mission of the Regional Centers in Nebraska is to provide acute inpatient and secure residential mental health services. While they have a few licensed alcohol and drug abuse counselors on staff to do dual enhanced programming, treating substance dependency and substance abuse is not a role

for the Regional Center. The expertise in substance treatment in Nebraska is in community based programs.

## **Board Determination of Dangerousness**

### *1. Magnitude, Likelihood, Imminence and Frequency*

The second decision at a commitment hearing is determining whether a person is dangerous—not only whether dangerousness *is present*, but also *to what extent* risk of violence or dangerousness toward self or others exists. Areas of dangerousness include: Suicide threat (verbal), suicide attempt, homicide threat (verbal), homicide attempt, threats to physically harm others, (verbal or nonverbal), destruction of property, and inability to provide the basic needs of food, clothing, shelter, safety, and medical care.

Dangerousness risk is a complex interaction of four factors of **Magnitude, Likelihood, Imminence, and Frequency (MLIF)**. Considering each of these factors can help assess the potential for violence.

\* **Magnitude** of danger concerns the level of danger presented. For example, threats to harm people would be considered more dangerous than threats to harm property; threats of physical harm to others would be more serious than psychological threats. The use of a weapon escalates the risk of danger, of course, but the choice of weapon must be taken into consideration. The harm posed by a gun would be greater than that posed by a knife because a gun is five times more likely to cause death than a knife.

\* **Likelihood** of dangerousness is the probability of occurrence of violence. While the best predictor of violence is past history of violence, research has shown that there are eight demographic elements which correlate statistically with an increased risk of violence:

1. Age: Violence peaks in the late teens and early 20's
2. Gender: Males are more violent than females. However, among the SPMI mentally ill population (Severely and Persistently Mentally Ill), the ratio of violent and aggressive acts is the same for males and females
3. Social Class: Lower socio-economic class members experience more street violence
4. IQ: Individuals with lower IQ's demonstrate more violence which may be related to an inability to talk out concerns or articulate needs
5. Education: Lower levels of educational achievement are associated with more violence
6. Employment: Risk of violence increases with job instability
7. Residence: Risk of violence increases with frequent changes of residence
8. Substance abuse: *Use of marijuana, alcohol, and other drugs increases the risk of violent behavior three-fold*; especially use of stimulants such as methamphetamine which reduce inhibitions and increase paranoia

\* **Imminence** of danger, how soon the danger might occur, is contained in the statute's description as "near future." Each mental health board should have a working consensus of the definition of imminent—whether it is defined as right now, or within twenty-four hours, the most commonly used time frame. Having this time definition set before being placed under pressure to make a decision regarding a commitment is helpful. The sooner violence may occur, the greater the risk of danger due to not having a chance to mitigate circumstances or provide protection.

\* **Frequency** is a factor when considering risks of dangerousness. Future violence is best predicted by past violence, as mentioned in likelihood of violence. The frequency of occurrence is a clear indicator that a pattern has been set and may be reoccurring.

## 2. *Risk Factors*

Risk factors can be static or dynamic. Some risks can be changed, for example, by taking away a weapon or the availability of a weapon. Another example could be when

psychosis is altered by enforcing oral medication compliance or by prescribing anti-psychotic medication delivered by injection, which can last from 2 to 4 weeks. The presence of a mental illness may be static, but the risks and deficits engendered by that condition may fluctuate.

It is important to note that the majority of the mentally ill population is not violent and dangerous, anymore than the majority of the general population. In fact, the percentage of overall violence in society attributed to those with mental illness or substance dependency is only **3%**. However, the likelihood of violence increases if a person's illness is active and in an acute stage. This is especially true if the illness is acute and psychotic. *Delusions* are more dangerous than hallucinations, especially when they are well organized, specific, and persecutory, i.e. "Blue-eyed people are really aliens who are out to get me." *Hallucinations* present a higher risk of violence if they are command auditory hallucinations, voices which command an individual to obey. If the command voice is familiar, like that of a parent, the person is more likely to obey the command. The most dangerous situation occurs when delusions are related to command hallucinations, with the delusions causing the hallucinations to make sense to the person, i.e., "Aliens are trying to take over the earth by replacing people with robots. My wife has been replaced with a robot. My deceased mother's voice whispers to me the only way I can get my wife back is to kill the robot imposter."

There are also risks from other forms of mental illness. While paranoid schizophrenia in an acute stage is more dangerous due to delusions and hallucinations, depression carries with it the risk of suicide. Those with manic mood symptoms may make more threats but cause less harm. People with personality disorders, especially those diagnosed with antisocial personality disorder who have no remorse for their behavior, and those who are impulsive, unable to accept redirection, pose a greater risk for violence.

Risk can also be assessed according to the potential for severity and occurrence, as delineated by the LOCUS parameters developed in 1997 by the American Association of Community Psychiatrists. The **Level Of Care Utilization System** rates potential for harm to self or others from minimal potential to extreme potential. An example of the rating system follows.

- Low potential for dangerousness: no indication of suicidal or homicidal thoughts or impulses; no history of suicidal or homicidal ideation; no indication of distress
- Moderate potential for dangerous behavior: significant current suicidal or homicidal ideation without intent or conscious plan and without past history; current distress may be present without active ideation, but a history of suicidal/homicidal behavior exists; past binge use of substances resulting in lack of inhibition and aggression towards others or self without recent episodes of such behavior; some evidence of self-neglect and compromise in ability to care for self
- Extreme potential for dangerous behaviors: current suicidal or homicidal behavior or intentions with a plan and means to carry out the plan; with a history of serious past attempts; or presence of command hallucinations or delusions which threaten to override impulse control; repeated episodes of violence toward self or others, or other behaviors resulting in likely harm to self or others while under the influence of alcohol or drugs; extreme inability to care for self or monitor the environment with deterioration in physical condition or injury related to these deficits.

Low potential correlates with consequences unlikely to result in harm, injury, property destruction, or no life threatening incidences. Even if imminent, the magnitude of danger

would be lower. Moderate potential would present greater magnitude, not as imminent, with consequences likely to result in harm, injury, or property destruction but without life threatening consequences. Extreme potential for dangerous behaviors is an acute level—high magnitude, imminent risk with consequences likely to include loss of life, limb, and/or major property destruction.

### *3. Spectrum of Aggressive Behavior*

Aggressive behavior also falls along a spectrum--from verbal threats to severe injury.

The following list of behaviors ranges from mild at number (a) to serious danger at number (d).

#### VERBAL AGGRESSION

- (a) Makes loud noises, shouts angrily;
- (b) Yells mild personal insults, e.g. "You're stupid!";
- (c) Curses viciously, uses foul language in anger, makes moderate threats to others or self; or
- (d) Makes clear threats of violence toward others or self, i.e. "I'm going to kill you!" or requests help to control self.

#### PHYSICAL AGGRESSION AGAINST OBJECTS

- (a) Slams door, scatters clothing, makes a mess;
- (b) Throws objects down, kicks furniture without breaking it, marks the wall;
- (c) Breaks objects, smashes windows; or
- (d) Sets fires, throws objects dangerously.

#### PHYSICAL AGGRESSION AGAINST SELF

- (a) Hits or scratches skin, hits self on arms or body, pinches self, pulls hair (with no or minor injury);
- (b) Bangs head, hits fist into object, throws self onto floor or into objects (hurts self without serious injury);
- (c) Small cuts or bruises, minor burns; or
- (d) Mutilates self, makes deep cuts, bites that bleed, internal injury, fractures, loss of consciousness, loss of teeth.

#### PHYSICAL AGGRESSION AGAINST OTHERS

- (a) Makes threatening gestures, swings at people, grabs at clothes;
- (b) Strikes, kicks, pushes, pulls hair (without injury);
- (c) Attacks others causing mild/moderate physical injury (bruises, sprains, welts); or
- (d) Attacks others causing severe physical injury (broken bones, deep lacerations, internal injury).

#### 4. *Danger to Self: Suicide*

An additional type of dangerousness a mental health board must determine is that of danger to self. When discussing the risks of dangerousness to self and suicide, several terms need to be defined:

- *Suicidal Ideation*—thoughts of ending one's own life  
    Passive Ideation—thoughts without a plan  
    Active Ideation—thoughts accompanied by a plan
- *Suicidal gesture*—self-inflicted harm done without a realistic expectation of death; possibly an attention-getting plea
- *Suicide attempt*—self-inflicted harm with clear expectation of death

Statistics from the year 2000 indicate that suicide is attempted 1,000,000 (one million) times a year. Of those attempted suicides, 1 in 18 is completed, with an annual death rate of 31,000.

One third of the population will have suicidal thoughts in their lifetime. Any threat, gesture, or act related to suicide needs to be taken seriously. The belief that a person who talks about suicide will not attempt it, is a fallacy.

The aim of suicide is not always death—it can be a cry for help, an attempt to reunite with a deceased loved one, or an escape from a life which has become intolerable due to depression, illness, or circumstances. Another underlying goal may be revenge; the belief that those left behind will suffer for their negative treatment of the person. The risk of a completed suicide is increased by depression, substance use, and disorganized thinking like that characteristic of schizophrenia.

A scale for evaluating the danger risk for suicidal patients was developed by Patterson, called the SADPERSONS scale.

**S = Sex:** Women make more attempts than men; however, due to men's choice of method, their attempts are more often fatal (gun versus pills)

**A** = Age: risk is greater for persons under 19 and over 45

**D** = Depression: greatly increases risk of suicide

**P** = Previous attempt: either by the person, or a family member (which makes suicide seem an acceptable choice when stressed)

**E** = Ethanol: alcohol use increases risk due to decreased judgment and increased impulsivity

**R** = Rational thinking: presence of impaired judgment

**S** = Social support: lack of meaningful, supportive relationships

**O** = Organized plan: the more organized the plan, greater the risk

**N** = No spouse: unmarried, divorced, widowed, separated people are at greater risk

**S** = Sickness: chronic debilitating conditions, pain

A signed contract for safety or no self-harm may decrease imminence of suicide and insure the possibility a person will not hurt himself at this time, but it is not a safeguard. Clients have willingly signed such a contract in order to avoid being taken into Emergency Protective Custody, or to get out of the mental health professional's office in order to make their planned attempt. There are several danger signs often found in the conversation of people who eventually attempt suicide. They include statements about hopelessness, helplessness, worthlessness, preoccupation with death and talk about suicide. Behaviors noted before suicide attempts were: losing interest in things previously cared about, setting affairs in order, and giving away prized possessions. Often people appeared suddenly happier, calmer, right before the attempt as though a decision had been made.

As with violence, the best predictor of suicide is history of previous attempts; or having a family member or close friend who completed suicide. The four factors of **Magnitude, Likelihood, Imminence** and **Frequency** can be applied to determining the risk of suicide as well. Information regarding the magnitude of harm, the proposed means of suicide, whether there is a family history of suicide the, and a history of previous attempts, is helpful in determining level of risk.

##### *5. Danger to Self: Self-neglect*

Suicide is not the only danger to self that a mental health board may encounter. Dangerous self-neglect includes risks due to inability to provide for the basic human needs of food, clothing, shelter, safety, and medical care. Inability to care for self may result from mental illness or alcohol or drug use. Impairment in activities of daily living include appearance and hygiene falling below acceptable standards, disturbance in sleep or eating patterns, homelessness, or putting self in harm's way, such as walking down the middle of a highway.

Self-endangering behaviors may be evident in the life of an alcohol or a drug-dependent persons; for example, drinking or drug use which compounds medical problems yet the person doesn't stop substance use despite deterioration in physical health. An alcohol dependant person on a binge or a methamphetamine user may not eat for days. Frequently alcohol dependant persons can become depressed and express thoughts of suicide or wanting to die while intoxicated. Addicts may seriously deplete family resources to the point that money is gone---leaving them and their families without resources for procuring food, shelter, clothing or medical needs. A substance dependent person may endanger not only his or her own life, but also the lives of others when driving while intoxicated or under the influence of drugs.

### **Information Required to Determine Commitment**

If not enough information about the four risk factors for dangerousness is presented to the board, members have a duty to discover any elements related to dangerousness by questioning the individual before them, the mental health professional, and any legal representatives. Questions about (1) the precipitating event that brought about the petition for a hearing, (2) the person's behavior and (3) past history will aid in determining dangerousness. A label of "dangerous" or "violent" applied to a person should not be

accepted at face value, but must rest on a report of the incident and behavior. These facts must always be ascertained:

1. **WHAT:** The events, the person's behavior, diagnosis, presence or absence of mental illness or substance use
2. **WHO:** Identity of the victim(s). Research has shown that the mentally ill are most likely to commit violence on family members; if the victim is a stranger there is a higher risk
3. **WHEN:** Date, time, and importantly—frequency
4. **WHERE:** Circumstances as well as place
5. **WHY:** Attempt to determine what triggered the violence; was it in retaliation for an imagined or real event; what was the motivation behind the behavior (Note that a predatory or cold and calculated violent act is more often lethal than one arising from an emotional trigger of the moment)
6. **HOW:** Determine if there is a pattern by inquiring about past behavior, as discovering a pattern helps make a prediction

Research can't predict violence, but it has found elements statistically related to likelihood of violence. Answers to the following questions may help a mental health board in determining risk.

1. MENTAL STATUS: Was the person psychotic or intoxicated?
2. MOTIVATION: Was this a predatory or calculated and planned act, or was the affective acting out from emotional impulse?
3. EMOTION: What were the person's feelings before, during and after the event? Does the person express remorse for the act? (Fear and anger are most commonly associated with violent or aggressive acts; lack of remorse or lack of empathy for the victim is more dangerous)
4. IMPULSE: Has the person demonstrated unpredictable and impulsive behavior in the past? Over-controlled behavior? (Over-controlled behavior can also result in danger when long repressed emotions erupt suddenly, triggered by the proverbial "straw that broke the camel's back".)
5. VICTIM(S): Was the victim familiar and known or was the act perpetrated against a stranger?
6. WEAPONS: Related to the element of magnitude—was a weapon used? What weapon and what magnitude of harm either resulted or could have resulted? For example, was a plate thrown at the wall in anger or was a gun used?

7. **STRESSORS:** What were the biological or medical stressors affecting the person? Were there increased psychological or social stressors affecting their lives such as a lost job, broken relationship, recently diagnosed medical condition? (These would be listed on Axis IV of the DSM diagnosis)

### **Questions for MH Board Members to Ask at Hearings**

The following list of questions would assist in gaining the insight required in order to select the most appropriate treatment option when making a commitment decision.

#### *1. Questions to Ask Mental Health Professional or Licensed Alcohol and Drug Abuse Counselor (LADAC):*

1. Is the client a danger to self or others?
2. What levels of care have you considered?
3. What is the least restrictive level of care that this client could be safely as well as effectively be treated?
4. What barriers are there to treating this client in the community? (lack of support system, inadequate transportation, etc.) Note that agencies which offer Community Support, both Mental Health and Substance Abuse/Dependence, provide transportation for clients as part of the service
5. What, if any, successful treatment history has this client had?
6. What tools were used in assessing this client? (face to face interview, record review, psychological testing, medical consult, family interview)
7. Was this client in a mental health or substance abuse/dependence service at the time they were placed under an EPC?
8. What is the diagnosis of the client? Does the client have a mental health diagnosis as well as substance abuse/dependence diagnosis? Are there any medical conditions that can worsen the mental health or substance abuse/dependence diagnosis? (Note: a diagnosis of dependency not abuse is required to commit a client to substance dependency treatment.)
9. Is this client medically and psychiatrically stable enough to participate in primary substance abuse treatment? (administer their own medications, perform activities of daily living, free from aggression)
10. If residential treatment is not recommended, is there a crisis plan for this client?

11. Are all the mental health providers involved in the assessment of this client in agreement regarding the current treatment recommendations?
12. What arrangements have been made for the treatment and commitment recommended for this client? (outpatient appointments, AA group location, transportation arrangements)

*2. Questions to Ask Subjects:*

1. Do you understand the recommended treatment plan?
2. What is your current diagnosis?
3. What medications are you taking and why do you take them?
4. Do you believe you can comply with the recommended treatment plan?
5. What would prevent you from succeeding in this treatment?
6. What current treatment are you receiving and with whom?
7. When was the last time you saw a mental health provider and who was it?

**The Commitment Decision**

**71-925 (6)**

(6) A treatment order by the mental health board under this section shall represent the appropriate available treatment alternative that imposes the least possible restraint upon the liberty of the subject. The board shall consider all treatment alternatives, including any treatment programs or conditions suggested by the subject, the subject's counsel, or other interested person. Inpatient hospitalization or custody shall only be considered as a treatment alternative of last resort. The county attorney and the subject may jointly offer a proposed treatment order for adoption by the board. The board may enter the proposed order without a full hearing.

It is the board's responsibility to decide where a person's interest would be best served. Clearly, according to the statute, inpatient hospitalization is the treatment modality to be considered **LAST**. Board members should familiarize themselves with mental health and substance dependency services available in the state of Nebraska and the agencies providing those services in their region. When criteria for dangerousness are not met, then the board can then determine which type of community based outpatient commitment would provide the necessary treatment in a less restrictive environment, while also ensuring public safety.

An appearance before a mental health board and subsequent committal can be a life-changing event, not always for the better. Along with the emotional trauma and disruption, there is always risk associated with hospitalization including hospital-acquired infections, and physical danger from peers whose symptoms are more acute and less well controlled. The rationale for use of least restrictive placement is based on research showing patient outcome is more positive in a less restrictive setting. Good treatment at the appropriate level of care is also cost effective; it prevents the need to treat a person again and again, and it prevents costly over-treatment at an unnecessary level of care.

In the case of substance dependency, for example, a high need for treatment can be accommodated by outpatient/community based commitment to a short-term residential substance abuse program. If short-term residential services are not available another alternative for community substance dependency treatment is commitment to an IOP (Intensive Outpatient) substance dependency program, and substance dependency community support.

### **The Board's Responsibility in Reassessing Level of Care Decisions**

When a commitment has been made, a mental health board has the option of re-evaluating a level of care decision.

If a person is not cooperating, not following conditions of release or not following an outpatient treatment plan, which may include their not taking the prescribed medication, then the treating mental health professional can inform either the board or the county attorney and a new hearing may be held.

Re-assessment of a level of care decision may also be necessary when a committed person, while waiting for an opening at an inpatient level of care center or residential substance abuse program, has been receiving treatment at a crisis center/hospital. If the board finds that (1) the person could no longer be considered mentally ill and dangerous; or (2) no longer substance dependent and dangerous; or (3) that no cause exists for care or treatment; or (4) that a less restrictive alternative exists--the board may order immediate discharge or change the treatment disposition per Neb. Rev. Stat. 71-935

Neb. Rev. Stat. 71-937 removes the language requiring seven days notice in advance of a release by a treatment facility.

### **Behavioral Health Reform in Community Based Services**

Mental Health Board members must look at least restrictive levels of care, which meet the behavioral health needs of the person. New and expanded community based services are being developed as a part of behavioral health reform to better meet the needs of persons who are mentally ill *and* dangerous.

Outpatient commitments should be considered in most cases, as they are less restrictive and less traumatic to the person. Outpatient services include **residential services**. Outpatient Commitments may be made to the following community based services in Mental Health:

Psychiatric Residential Rehabilitation, Day Treatment, Community Support, Day Rehabilitation, Outpatient Therapy, and Medication Management. Commitment *may be made to more than one service, if needed, such as community support and medication management.*

Outpatient Commitments may be made to the following community based services in Substance Dependency:

Short Term Residential, Therapeutic Community, Halfway House, Partial Care, Intensive Outpatient, Community Support, and Outpatient Therapy. Commitment *may be made to more than one service, if needed, such as community support and outpatient therapy.*

The Mental Health Board may commit the person to Outpatient – directly to a provider of one of the above-mentioned services or, under the new legislation, to HHS for Inpatient (Acute or SubAcute) which will be provided through the Behavioral Health Regions by contracts with providers of Acute/SubAcute care. The Crisis Center would contact Providers of Inpatient (Acute and SubAcute care) and these services would be pre-authorized through Magellan Behavioral Health, the contracted provider of (ASO) Administrative Services Only. A list of providers of Acute and SubAcute care is available from the Division of Behavioral Health, P.O. Box 98925, Lincoln, NE 68509-8925.

As a result of the passage of LB1083, Mental Health Boards are to commit mentally ill and dangerous persons to Nebraska Health and Human Services for inpatient (Acute and SubAcute) care. HHS, through the community hospitals, and the state six behavioral health regions and the state

hospital, will provide the level of care necessary as determined by the mental health board upon reviewing the Professional Affidavit, testimony, and other pertinent information presented at the Mental Health Board hearing. A list of providers of mental health and substance abuse services in each region is available at the following address:

Division of Behavioral Health Services  
P.O. Box 98925  
Lincoln, NE 68509-8925.

As a part of LB1083, changes were made in training requirements for Mental Health Board Members. Under the new legislation, Mental Health Board Members must be trained **prior to serving on the Board**. Another change is that members must satisfactorily complete Mental Health Board Training at least once every four years.

## **Conclusion**

The mental health commitment process involves three decisions. First, a determination must be made whether a person is mentally ill and/or substance dependent. The second decision in the process to commit or discharge is assessing for risk of dangerousness to self or others. Using the four factors of magnitude, likelihood, imminence, and frequency, a determination can be reached more readily. Finally, if a committal is deemed necessary, by law placement must be to the least restrictive level of care which would successfully treat the mental illness/substance dependence and prevent harm to self or others.

Mental health board members serve as part of a system of checks and balances, guarding an individual's personal rights while ensuring due process and protecting public safety. The board obtains information through questioning those at the hearing, the mental

health/substance abuse professionals, legal representatives and most importantly the person appearing before them. Based on that evidence, an objective decision can be made whether *clear and convincing evidence* has been presented that a *substantial risk of serious harm* exists within the *near future*.

The Mental Health Commitment Act was not created to punish behavior caused by mental illness. Rather, by mandating treatment for those either unable or unwilling to seek treatment on their own, due to mental condition or diagnosis, the Act protects their safety, the safety of society, and provides an individual with treatment which can lead to an improved quality of life.

### **Forced Medication**

Section 71-959(3) provides that a subject has a right to refuse medication except “following a hearing and order of a mental health board, such treatment medication as will substantially improve his or her mental illness.”

The foregoing provision, enacted in 2004, simply brought Nebraska’s statutes in line with U.S. Constitutional requirements as articulated by the U.S. Supreme Court in Mills v. Rogers, 457 U.S. 291 (1982) and Washington v. Harper, 494 U.S. 210 (1990). The Mills case involved the rights of an individual committed to treatment through a civil process similar to the Nebraska Mental Health Commitment Act. These two cases stand for the proposition that it is unconstitutional in our country to medicate someone against their will, without first providing them with a Due Process hearing on the issue of forced medication.

This proposition was more recently articulated in Sell v. U.S., 539 U.S. 166 (2003), a criminal case in which the defendant was found to be not competent to stand trial and a danger to himself and others. Mr. Sell refused to take medication to make him competent to stand trial on felony charges. The Court held that under the Constitution, the government may administer drugs to render an individual competent to stand trial, if a due process hearing is given and the state’s reasons are more compelling than the subject’s reasons for refusing. The Sell decision also sheds light on what issues an impartial hearing body such as the Mental Health Board should consider when weighing the issue of forced medication, including:

- whether the medication is medically appropriate
- whether any alternative treatments are likely to succeed
- the likelihood and severity of drug side effects
- the likelihood of long term impact on the patient’s health
- whether the medication is likely to produce significant improvements
- whether the refusal to take the drug puts the patient or others at risk.

Constitutional rights apply to all citizens of the US. Moreover, civilly committed patients have the same Constitutional protections as do criminal defendants. Mills stands for the proposition that civilly committed patients enjoy Due Process protections in this regard. The same considerations that were applied in Sell are also applicable to Mental Health Board hearings on forced medication decisions. Basic Due Process protections would include a right to notice of the hearing, the medication that the State wishes to administer and an opportunity to defend his or her refusal to take that particular medication.

Even though the Nebraska statutory provision, 71-959(3) was enacted in 2004, the US Constitutional law that underpins the statute goes back over 23 years.

It should be clear from the foregoing that an attempt by the Mental Health Board to include “boilerplate” language in a commitment order granting the blanket authority to force medicate without first addressing the issues covered in this memo will not pass constitutional scrutiny. The subject is entitled to a due process hearing on these issues before a forced medication order can be entered in order to be consistent with the statutory and constitutional scheme.

#### Access by Law Enforcement to Mental Health Board File

#### **Can law enforcement access the Mental Health Board’s File or other documents held by the Mental Health Board?**

NRS Sec.71961 (1) Provides:

All records kept on any subject shall remain confidential except as otherwise provided by law. Such records shall be accessible to (a) the subject, except as otherwise provided in subsection (2) of this section, (b) the subject’s legal counsel, (c) the subject’s guardian or conservator, if any, (d) the mental health board having jurisdiction over the subject, (e) persons authorized by an order of a judge or court, (f) persons authorized by written permission of the subject (g) agents or employees of the Department of Health and Human Services Regulation and Licensure upon delivery of a subpoena from the department in connection with a licensing or licensure investigation by the department, or (h) the Nebraska State Patrol or the Department of Health and Human Services pursuant to section 69-2409.01

The phrase “all records kept on any subject” is not specifically delineated in statute, but reasonably includes records in the possession of the Mental Health Board as well as the file and other documents maintained by clerk of the district court (see 71-917).

**Nothing in the statutes gives any law enforcement agency automatic access to such confidential records, absent one of the exceptions set forth in 71-961 (1).** Put another way, without one of the exceptions in 71-961(1) having first been met, the mental health board has no authority to release its records to law enforcement. Note that per subsection (e), the Board can be authorized to release information per a court order. A court order is not a subpoena. If a law enforcement agent presents a subpoena for records in the possession of the Board, that alone would *not* authorize release.

Pursuant to section 69-2409.01, the Nebraska State Patrol is granted very limited access, upon request, “information as may be necessary for the sole purpose of determining whether an individual is disqualified from purchasing or possessing a handgun pursuant to state or federal law.” Such information, according to the foregoing statute, “Shall be furnished by the Department of Health and Human Services”. Thus, nothing in statute authorizes the mental health board to furnish information in its possession to law enforcement.

### **Statutory Role of MHB Duties and Responsibilities**

According to 71-905, “mental health board” means a board created under section 71-915.

#### **Synopsis of NRS Sec. 71-915**

##### **Subsection 1 Creation**

The presiding judge in each district court judicial district shall create at least one but not more than three mental health boards in such district and shall appoint sufficient members and alternate members to such boards. Terms are for 4 years but the presiding judge may remove members/alternates at his discretion.

### **Immunity**

Members of the MHB shall have the same immunity as judges of the District Court.

##### **Subsection 2**

###### *Composition*

Each MHB shall consist of a licensed attorney and any two of the following but not more than one from each category:

Physician

Psychologist

Psychiatric social worker

Psychiatric nurse

Clinical social worker

Layperson with a demonstrated interest in mental health and substance dependency issues.

###### *Chairperson*

The attorney shall be chairperson of the board.

###### *Oath*

Members/alternates shall take an oath to support the US and Nebraska Constitution and to faithfully discharge the duties of the office.

##### **Subsection 3**

###### *Powers*

MHB shall have the power to issue subpoenas, to administer oaths, and to do any act necessary and proper for the board to carry out its duties.

###### *Presence of Members Required/ Majority Vote*

No MHB hearing shall be conducted unless three members or alternate members are present and able to vote. Any action taken at any MHB hearing shall be by a majority vote.

#### Subsection 4

##### *Duty to File Inventory*

MHB shall file an annual inventory statement with the county board of all county personal property in its custody.

##### *Compensation/Reimbursement*

Members of the MHB shall be compensated and reimbursed for actual and necessary expenses, not including charges for meals, by the county served by such board. Compensation shall be at an hourly rate determined by the presiding district court judge, except that compensation shall not be less than fifty dollars for each hearing of the board.

### Synopsis of NRS Sec. 71-916

#### Subsection 1

##### *Training by HHS*

HHS shall provide training to members/alternates. No person shall remain on a MHB or be eligible for appointment unless he/she has attended and satisfactorily completed such training pursuant to rules and regulations adopted by HHS.

##### *Reimbursement*

Members/alternates shall be reimbursed for any actual and necessary expenses incurred in attending such training in an amount determined by the presiding judge of the district court.

##### *Forms*

HHS shall provide the MHB's with blank forms and copies of rules and regulations of the department that will enable the MHB's to carry out their powers and duties.

## **INSTRUCTIONS FOR SELF-STUDY REQUIRED EXAM**

**The Self study handbook and appendices must be read prior to completing the self study exam. The exam is based on the information in the self-study handbook and appendix. It is recommended that 75% of the questions be answered correctly for a satisfactory completion of Mental Health Board training.**

**Complete all of the questions on the Self Study exam. You may use any of the materials in the Self Study Handbook to answer the questions. Be sure to answer all the questions as completely as possible. Write, print legibly, or type so you will be given full credit for your answer. If your answer cannot be easily read, it will not be scored.**

**The self-study exam must be completed, sent and received in the Division of Behavioral Health Services. Your certificate will be mailed to you after your exam is scored. If you have any questions regarding the Self Study please contact Kathleen Samuelson at 402 475-5575 or Dan Powers at 402 479-5193.**

**Send your completed self-study exam to:**

**Kathleen Samuelson or Dan Powers  
MH Board Training Coordinators  
Division of Behavioral Health Services  
P.O. Box 98925  
Lincoln, NE 68509-8925**

Mental Health Board Training  
**SELF STUDY EXAM**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: NE Zip Code \_\_\_\_\_  
Judicial District: \_\_\_\_\_ Mental Health Board: \_\_\_\_\_  
Classification(attorney, physician, layperson, etc) \_\_\_\_\_

Multiple Choice (circle the one correct answer):

1. The level of evidence necessary for commitment is:
  - A. Beyond reasonable doubt
  - B. Clear and convincing
  - C. Clear and unequivocal
  - D. Preponderance of the evidence
2. To commit an individual he/she must be found to be:
  - A. Dangerous
  - B. Mentally ill or substance dependent
  - C. A and B
  - D. Intoxicated
3. In Wickwire's case the court ruled that a mental health board:
  - A. May commit persons with mental illness
  - B. May commit persons with mental illness only if they are substance abusers
  - C. May not commit people with mental retardation
  - D. May commit persons with mental retardation if they are dangerous
4. Mental Illness is a:
  - A. Thinking disorder
  - B. Mood disorder
  - C. Substance dependence
  - D. All of these
5. The four factors in dangerousness are:
  - A. Magnitude, likelihood, imminence, frequency
  - B. Age, intelligence, gender, social class
  - C. magnitude, likelihood, intelligence and frequency
  - D. Diagnosis, prognosis, insight, orientation
6. The best predictor of violence is:
  - A. A past history of violence
  - B. A DSM diagnosis
  - C. A law enforcement officer
  - D. A board certified psychiatrist
7. The percentage of overall violence in society attributable to mentally ill or dependent persons is:
  - A. .05%
  - B. 3%
  - C. 10%
  - D. 25%
8. The greatest potential for danger is represented by:

- 
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17. True or False: Risk of violence is greatest in mental illness when delusions cause hallucinations to make sense to a person.

True

False

18. True or False: A person who talks openly about suicide will not make an attempt.

True

False

19. True or False: A person with suicidal ideation really wants to die.

True

False

20. True or False: Blackouts are a symptom of alcohol dependence/alcoholism.

True

False

21. List three rights of a subject at a mental health board hearing.

(1)

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(2)

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(3)

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22. List 3 questions you will ask the subject and/or the mental health/substance abuse professional at the next mental health board hearing:

(1)

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(2)

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(3)

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23. Identify one change you will personally make in your commitment decision making process at the next mental health board hearing, because of the information presented in this study guide?

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24. When mental health boards commit an individual to an inpatient (acute or sub-acute) level of care, the order places the individual into the custody of:

(1) A given regional center

(2) A given provider

(3) A given community hospital

(4) Department of Health and Human Services

25. Medication can be “forced” on a committed individual under which of the following circumstances? Choose all that may apply.

- (1) In an emergency to prevent injury to self or others
  - (2) When the treating physician determines it is in the best interest of the individual
  - (3) Following a hearing and order of a mental health board that such treatment medication will substantially improve the mental illness
  - (4) To help the individual assist in their defense at a hearing.
26. The majority of apprehended sex offenders have which of the following DSM diagnoses (choose all that may apply):
- a. voyeurism
  - b. pedophilia
  - c. sexual sadism
  - d. exhibitionism
  - e. sexual masochism
27. Pedophilia is often associated with which of the following co-occurring personality disorders (choose all that may apply):
- a. dependent
  - b. schizotypal
  - c. obsessive compulsive
  - d. antisocial
  - e. histrionic
28. The recidivism rate for persons with pedophilia with a preference for boys is:
- a. the same as for those with a preference for girls
  - b. less than for those with a preference for girls
  - c. more than for those with a preference for girls

**Please read the following two case scenarios and answer all questions as completely as possible. PLEASE WRITE OR PRINT LEGIBLY OR TYPE ON A SEPARATE SHEET OF PAPER.**

**29. CASE SCENARIO #1**

A 40 year-old male was EPC'd from his home in a rural trailer park; he had called a friend after the bar closed Friday night and said he might as well kill himself. The friend called the police; they found a loaded shotgun by the back door. The man told police he was becoming more depressed, had reached the end of his rope, was way behind on his bills and didn't see a way to catch up.

After two days in the Crisis Center, the man now denies feeling suicidal. He shows some signs of depression: difficulty concentrating, feelings of helplessness, excessive sleep. However, until the incident he had continued to work and had gone to the bar every night at 5 p.m. He admitted smoking marijuana every now and then, "just to relax." He denies he has a drinking problem, since all his friends go to the bar after work. He has no psychotic symptoms, no violence history, the only legal involvement was a DUI last month. He is physically healthy, had not been taking any prescribed medications, has not had any previous mental health or substance abuse treatment.

His mental health diagnosis is:

Axis I Major depressive disorder, single episode, mild  
Alcohol abuse, Cannabis abuse

Axis II Deferred

Axis III Asthma

Axis IV Difficulties with primary support, economic problems

Axis V GAF 55

- A. What questions would you ask a clinician about the subject's diagnosis to help determine if mental illness is present. Explain why you would ask each question.
- B. What questions would you ask to help you determine dangerousness?
- C. What evidence of magnitude, likelihood, imminence and frequency is present?
- D. What decision regarding commitment and level of care/services do you believe would be appropriate for this man? List your reasons for your decision.

### 30. CASE SCENARIO #2

A 21 year-old female is brought to the Crisis Center after she was found rummaging through the trash behind Wal-Mart. She was seen roaming the parking lot, talking and gesturing to herself. She refuses to answer any direct questions, continues to hum under her breath, is dirty, disheveled, and dressed inappropriately for winter weather. She stated that she knows the staff can read her mind, so she is humming to confuse them. After a physical exam, she is found to be malnourished and underweight. The consulting psychiatrist requests a mental health board hearing after she has been on the unit for two days because she has refused to take any medication, claiming that the staff is being paid to poison her. She has an aunt and uncle living in a small town thirty miles away. When reached, they state she was enrolled at the local community college but had not been in contact with them for several weeks. As far as they know she has not used drugs, has never seen a psychiatrist, has no previous history of bizarre behavior.

Her mental health diagnosis is:

Axis I Paranoid Schizophrenia

Axis II Deferred

Axis III Malnutrition

Axis IV Primary support, economics, social, accessing medical care

Axis V GAF 25

- A. What questions would you ask clinician about subject's diagnosis?
  
  
  
  
  
  
  
  
  
  
- B. What questions would you ask to determine level of dangerousness?
  
  
  
  
  
  
  
  
  
  
- C. What evidence of dangerousness is present? Is the risk low, moderate, or extreme? Explain why you think low, moderate or extreme risk level in your answer.
  
  
  
  
  
  
  
  
  
  
- D. What decision regarding care/services would be appropriate for this young woman? List your reasons for your decision.

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